STATE OF MICHIGAN
IN THE SUPREME COURT

BRONSON METHODIST HOSPITAL,
A Michigan non-profit corporation,

Plaintiff-Appellee,

v

MICHIGAN ASSIGNED CLAIMS FACILITY,

Defendant-Appellant.

Supreme Court No. 151343
Court of Appeals Nos. 317864, 317866
Kalamazoo Circuit No. 12-0600-NF

AMICUS CURIAE BRIEF OF THE MICHIGAN INSURANCE COALITION IN SUPPORT OF APPELLANT'S APPLICATION FOR LEAVE TO APPEAL

Respectfully submitted,

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STATEMENT OF INTEREST OF *AMICUS CURIAE*

The Michigan Insurance Coalition (MIC) is the government affairs and public information organization for a group of insurers in the Michigan property/casualty insurance industry. It is comprised of insurance companies based in Michigan and around the country. Insurers writing insurance in Michigan are required to participate with appellant Michigan Assigned Claims Plan[1] pursuant to MCL 500.3171(1). Michigan insurers have a direct financial interest in this case because they are required to pay the operating costs incurred by the Michigan Assigned Claims Plan. See MCL 500.3171(1). This, in turn, will force MIC members to raise their own rates, thus harming the vast number of Michigan citizens that they insure because insurers are in the final analysis surrogates for the consumers who pay for insurance.

INTRODUCTION AND REASONS SUPPORTING APPEAL

This case presents an issue of great importance to the jurisprudence of this state: should no-fault consumers bear the costs of unnecessary litigation to ascertain an injured person's insurance coverage all because a medical provider, the entity best positioned to determine coverage because of direct access to the injured person, failed to obtain this information when treating the injured person (for a broken pinkie finger). Further proceedings are unnecessary because further discovery will not change the fact that the injured person is not entitled to coverage from the Michigan Assigned Claims Plan. Costs incurred by the Michigan Assigned Claims Plan are paid by insurers, who in turn pass these costs to the consumers. The instant case is but one of many that demonstrates abuse of the no-fault system by medical providers who tap the cash cow rather than seek payment from their patients.

[1] As pointed out in the Court of Appeals opinion, the Michigan Assigned Claims Facility was replaced with the Michigan Assigned Claims Plan during the pendency of these proceedings. For consistency's sake, amicus will refer to the Michigan Assigned Claims Plan.

STATEMENT OF FACTS

Michigan Insurance Coalition adopts the statement of facts contained in the Michigan Assigned Claims Plan's application for leave to appeal.

STANDARD OF REVIEW

Michigan Insurance Coalition agrees with the standard of review stated in the Michigan Assigned Claims Plan's application for leave to appeal.

LEGAL ARGUMENT

1. This Case is but one of many Illustrating how Unnecessary Litigation Brought by Medical Providers Raises the Costs of No-Fault Insurance, which are then Borne by the Consumers of this State.

A. Because No-Fault Insurance is Mandatory, Cost Containment is Constitutionally Required To Be Considered In Interpreting the Act.

In order for the no-fault system to work, purchase of insurance must be compulsory "whereby every Michigan motorist [is] required to purchase no-fault insurance." *Shavers v Atty Gen,* 402 Mich 554, 578; 267 NW2d 72 (1978). The *Shavers* Court concluded that because no-fault insurance was compulsory, drivers had a due process right that required the state to ensure that insurance was available at fair and equitable rates:

> "We therefore conclude that *Michigan motorists are constitutionally entitled to have no-fault insurance made available on a fair and equitable basis*. [402 Mich at 559, 600 (emphasis added).]"

Thus, cost containment is an important consideration in construing the act in conformity with the constitutional constraints. See *Griffith v State Farm Mut Automobile Ins Co*, 472 Mich 521, 539; 697 NW2d 895 (2005) ("Plaintiff's interpretation . . . stretches the language of the act too far, and, incidentally, would largely obliterate cost containment for this mandatory coverage. We have always been cognizant of this potential problem when interpreting the no-fault act, and we are no less so today").

B. Costs Incurred by the Michigan Assigned Claims Plan Are Passed to Insurers, Which In Turn Pass the Costs to the Consumers.

Insurers writing no-fault insurance in Michigan are required to participate in and pay the operating costs incurred by the Assigned Claims Plan:

> A self-insurer and insurer writing insurance as provided by this chapter in this state shall participate in the assigned claims plan. Costs incurred in the operation of the facility and the plan shall be allocated fairly among insurers and self-insurers. [MCL 500.3171(1).]

Insurers account for these costs when establishing the rates they charge to consumers:

> Reasonable costs incurred in the handling and disposition of assigned claims, including amounts paid pursuant to assessments under section 3171, shall be taken into account in making and regulating rates for automobile liability and personal protection insurance. [MCL 500.3176.]

Insurers are thus surrogates for consumers who ultimately pay for increased charges. It is thus important to minimize these charges. "Because the first-party insurance proposed by the act was to be compulsory, it was important that the premiums to be charged by the insurance companies be maintained as low as possible. Otherwise, the poor and the disadvantaged people of the state might not be able to obtain the necessary insurance.'" *Griffith v State Farm Mut Auto Ins Co*, 472 Mich 521, 539 n 15; 697 NW2d 895 (2005), quoting, *O'Donnell v State Farm Mut Ins Co*, 404 Mich 524, 547; 273 NW2d 829 (1979).

C. Costs Should Not Be Unnecessarily Increased by Irrelevant Court Proceedings Which Will Not Change the Result.

The Court of Appeals opinion in the instant case results in unnecessary costs being passed to consumers. This Court has recognized that summary disposition is desirable when appropriate. *Moll v Abbott Lagoratories*, 444 Mich 1, 26-28; 506 NW2d 816 (1993). When a case may be resolved as a matter of law through summary disposition, the expense of further proceedings is unnecessary. "Summary disposition is intended to facilitate two important Michigan public policies: resolution of disputes on their merits, and avoidance of unnecessary expenditures where there is no actual dispute or where the only material dispute is over a point of law." *Minter v Grand Rapids*, 275 Mich App 220, 230; 739 NW2d 108 (2007), rev'd on other grounds 480 Mich 1182 (2008). Moreover, summary disposition is appropriate when further discovery does not stand a chance of changing the outcome. *Village of Dimondale v Grable*, 240 Mich App 553, 566; 618 NW2d 23 (2000). "[I]t would be futile to require that discovery be completed before a final decision can be made if discovery could not aid in deciding the case."

American Community Mut Ins Co v Comm'r of Ins, 195 Mich App 351, 363; 491 NW2d 597 (1992).

It is not enough to avoid summary disposition by simply identifying an issue of fact. There must be a genuine issue of *material* fact to avoid summary disposition. "A material fact is an ultimate fact issue upon which a jury's verdict must be based." *Belmont v Forest Hills Pub Schs*, 114 Mich App 692, 696; 319 NW2d 386 (1982), citing *Partrich v Muscat*, 84 Mich App 724, 730 n 3; 270 NW2d 506 (1978). In other words, "the disputed factual issue must be material to the dispositive legal claim." *Auto Club Ins Ass'n v State Auto Mut Ins Co*, 258 Mich App 328, 333; 671 NW2d 132 (2003). If the dispositive legal claim may be resolved regardless of the outcome of the factual issue, then the disputed factual issue is not a material one.

This concept has been recognized in several Court of Appeals cases pertaining to coverage. Although the cases did not articulate their discussion in the context of the same dispositive issue, they support the Assigned Claims Plan's position because they hold that when neither outcome as to a disputed issue leads to a duty to indemnify, an insurer should be granted summary disposition on coverage. Thus, a denial of summary disposition for an insurer was reversed in *Smorch v Auto Club Group Ins*, 179 Mich App 125, 129, 130; 445 NW2d 192 (1989):

> The rationale behind this is that, *regardless of the jury's finding* on the self-defense issue, *the insurer would be under no duty to pay* on behalf of the insured. Where the jury accepted the insured's version of self-defense, there would be no liability on the part of the insured. If the jury rejected the insured's version of self-defense, the insured would have committed an intentional act not covered by the policy. Where neither outcome leads to a duty of the insurer to pay on behalf of the insured, we will refuse to impose on the insurer a duty to defend.
>
> * * *
>
> Thus, the trial court's conclusion that it would deny Auto Club's motion for summary disposition on the basis that a question of fact existed as to whether

> plaintiff inflicted the alleged injuries was incorrect. ***. No matter how the assault and battery claim is resolved, Auto Club is not liable and has no duty to defend plaintiff. [internal citations omitted.]

The decision in *Smorch* was followed in in another case supporting the point that where neither outcome leads to coverage, an insurer should be granted summary disposition. Denial of an insurer's motion for summary disposition was reversed in *Auto Club Group Ins Co v Burchell*, 249 Mich App 468, 484, 486-487, 489; 642 NW2d 406 (2001):

> Regardless of whose version of events is believed, we conclude that there is no coverage . . .
>
> * * *
>
> [S]hould the jury believe plaintiff's version that the incident did not occur, neither plaintiff nor Auto Club would be liable for damages. Should the jury reject plaintiff's version, he would have committed an intentional act not covered by the policy. In either case, Auto Club is not liable and, thus, has no duty to defend.
>
> * * *
>
> Reversed and remanded for entry of summary disposition in favor of Auto Club. [internal citations omitted.]

In the instant case, the Court of Appeals noted: "Whether Esquivel failed to maintain statutorily required insurance for his vehicle constitutes an unresolved question of fact." *Slip op* at 7. However, the Court failed to recognize that the unresolved question of fact was not material to whether the Michigan Assigned Claims Plan was required to assign the claim to an insurer. Cf. *Smorch, supra.* Still, the Court of Appeals acknowledged that "Bronson agreed with the MACP that 'this can play out in two different ways,' one ending with coverage from some insurer and the other ending in no coverage." *Slip op* at 4.

Because neither result would require the Michigan Assigned Claims Plan to assign the claim to an insurer, the expenses of assigning the claim, investigating whether the injured party

had coverage, participating in discovery, and possibly litigating are all expenses unnecessarily incurred, which are passed on to consumers, all because Bronson did not do its homework when it had the opportunity to do so.

D. The Instant Case is One of Many that Illustrate the Error of Allowing Medical Providers to Pursue Direct Causes of Action.

It is axiomatic that the person in the best position to determine whether the injured person has insurance coverage is the injured person. The next best entity to determine whether the injured person has coverage is the entity that comes in contact with the injured person. When the injured person does not personally apply to the Michigan Assigned Claims Plan for coverage, the only entity that comes into contact with the injured person is the medical provider. The medical provider should not be permitted to shift the expense of its failure to ascertain coverage onto the consumers of this state. Courts often say that when one of two innocent parties must suffer a loss, it should be borne by the one whose conduct made the loss possible. E.g., *Langschwager v Pinney*, 351 Mich 473; 88 NW2d 276 (1958).

> A gross fraud was committed by Jones and Hoisington. The loss must fall either upon complainant or Henderson. Upon principles of equity, which of them should bear this loss? If the conduct of each had been equally prudent and unexceptionable, and neither had contributed more than the other to put it in the power of the wrong-doers to commit the fraud, the equities of both might be equal, and the court might leave the parties where they have placed themselves, without aiding either. But if either, by gross carelessness, has put it in the power of the wrong-doers to commit a fraud, which must result in a loss to himself or to some innocent third person, he should bear the loss who thus improvidently enabled the wrong-doers to commit the fraud. [*Bloomer v Henderson*, 8 Mich 395, 405-406 (1860).]

In the instant case, Bronson failed to obtain the injured party's insurance information and now cannot find the person to bill any insurance company that person might have. As this Court recently recognized, the medical provider retains the right to pursue the injured person for the services provided.

> No-fault benefits are "payable to or for the benefit of an injured person . . . ." MCL 500.3112. In this case, through settlement, the benefits were paid to plaintiff. *** [T]he effect of this was only to settle claims as between the insurer, plaintiff, and her attorney. *The circuit court's order of dismissal pursuant to the settlement agreement did not have the effect of extinguishing the DMC's right to collect the remainder of its bill from plaintiff.* [*Miller v Citizens Ins Co*, 490 Mich 904; 804 NW2d 740 (2011) (emphasis added).]

Thus, plaintiff has a second way to get insurance information, just sue its patient. However, instead of pursuing its contractual right of action against the injured person, and in the process ascertaining whether the injured person in fact does or does not have insurance (whether health or no-fault), Bronson has attempted to take the path of least resistance and place the burden of tracking down this person and determining coverage availability on the consumers of this state by filing a claim with the Michigan Assigned Claims Plan. This is but one of the many abuses to the no-fault system currently perpetrated by the medical community.

The Legislature has not granted medical providers the right to sue under the plain language of the no-fault act. In fact, MCL 500.3157 and MCL 500.3158(2) actually demonstrate the Legislature's intent that medical providers *not* actively pursue insurance companies. While MCL 500.3157 states that providers may charge a reasonable amount and does not specifically state that the providers are to charge the injured insured, MCL 500.3158(2) makes clear that dates and costs of treatment *must* be provided to the insurer but only *upon the insurer's request*, thus belying any purported intent in MCL 500.3157 that the providers may bill the insurers directly.

Nor has the Legislature treated medical providers as third-party beneficiaries with rights to sue under contracts between insurers and insureds. See MCL 600.1405. Recently, with regard to a fraud analysis, this Court stated, "there is simply no basis in the law to support the proposition that public policy requires a private business in these circumstances to maintain a source of funds for the benefit of a third party with whom it has no contractual relationship."

Titan Ins Co v Hyten, 491 Mich 547, 568; 817 NW2d 562 (2012). However, medical providers have been permitted to file separate suits against insurers which have resulted in an explosion of satellite suits pertaining to single occurrences. Insurers have to pay the legal costs of defending against multiple suits pertaining to a single occurrence (with pass-through costs to consumers), and courts are burdened with duplicative litigation, which can result in inconsistent outcomes.

Lakeland Hosps at Niles & St. Joseph, Inc v Auto-Owners Ins Co, Supreme Court Docket No. 151292, highlights the worst-kept secret in the history of the no-fault act – that medical providers routinely shift costs incurred in rendering medical care to the general public to those patients covered by the no-fault act, despite the fact that no-fault insurers are responsible only for those benefits for injuries arising out of the use of a motor vehicle as a motor vehicle. MCL 500.3105(1).

The no-fault arena has become the golden mecca for the medical industry. Providers file suits at will regardless whether their no-fault patients have filed suit, shift costs onto no-fault carriers from non-no-fault patients, and now, under the Court of Appeals decision in the instant case, are not even required to ascertain whether their patients have insurance coverage. All these abuses of the system increase the costs of no-fault, which then trickle down and are borne by Michigan consumers. Such practices violate the very cost-containment considerations that this Court has deemed essential to maintaining the due process right to secure this mandatory coverage. Given the cost-containment considerations necessary to maintain the constitutionality of the system, the medical industry's practices cannot be what the Legislature intended.

CONCLUSION AND RELIEF REQUESTED

Amicus requests that this Court grant the Michigan Assigned Claims Plan's application for leave to appeal in the instant case, reverse the Court of Appeals decision, and hold, consistent with cost containment considerations, that the Michigan Assigned Claims Plan is not required to do the homework of medical providers who fail to ascertain whether the very people they are treating have coverage.

Respectfully submitted,

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